STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235377	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Care Center	1050 Four Mile NW Grand Rapids, MI 49544

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to perform First Aid and Cardiopulmonary Resuscitation (CPR) per the standards of practice in 1 (Resident #140) of 4 residents reviewed for death resulting in an Immediate Jeopardy when on [DATE] at approximately 7:10 am, Resident #140, whose advanced directive indicated he was a full code (every possible life-saving therapy if a serious event occurs, such as cardiac or respiratory arrest) was found by facility staff in a pool of blood and without a heartbeat. Neither First Aid nor CPR was initiated, and Resident #140 was pronounced dead by Emergency Medical Services (EMS) at 7:36 AM. This deficient practice placed 67 residents that reside in the facility with the status of full code at risk or serious harm, injury, impairment, or death. Findings include: The Immediate Jeopardy began on [DATE] at approximately 7:10 AM when LPN Q and RN TT failed to initiate life saving measures to Resident #140 when he was found on the floor in a pool of blood without a heartbeat. Nursing Home Administrator (NHA) A was notified of the Immediate Jeopardy on [DATE] at 12:56 PM. The surveyor confirmed by observation, interview and record review that the Immediate Jeopardy was removed on [DATE], but noncompliance remains at a scope of isolated and severity of actual harm that is not immediate jeopardy due to not all staff had received education and sustained compliance that has not been verified by the State Agency. Resident #140 Review of an admission Record revealed Resident #140 was originally admitted to the facility on [DATE] with pertinent diagnoses which included end stage renal disease and essential hypertension (high blood pressure). Review of Resident #140's Code Status Form dated [DATE] and signed by Resident #140 revealed, I understand that by signing below that I will receive Cardiopulmonary Resuscitation (CPR) in the event that my heart stops or I stop breathing. By signing below as the legally responsible party I understand that the resident wishes are consistent with receiving CPR as described .Review of Resident #140's Progress Note dated [DATE] at 17:28 (5:38 PM) and documented by Licensed Practical Nurse (LPN) Q revealed, At 7:10 CNA (Certified Nursing Assistant) alerted this LN (Licensed Nurse) this pt (patient). (Resident #140) was on the floor in a lot of blood. LN immediately ran to room to see pt. lying in a very large pool of blood. LN checked signs of life, called to pt rubbing chest, no response. Looked for breath sounds, checked for a pulse and oxygen level. Nursing in room as 911 notified for stat (immediate) assistance. RN arrived on scene within a few minutes checking for signs of life, negative. Site was not deemed safe for CPR. Large pool of blood from chair at window side then to foot of bed wear (sic) pt. lay. Pt. last visited with in bed at 06:45 AM when he had asked for coffee. Pt appears to have self-transferred from bed without calling for assistance. Bandage site to right arm fistula (a surgically created connection between an artery and a vein, to provide a durable access point for hemodialysis) off and on floor. EMS (Emergency Medical Services) arrived at 7:30 AM. Pt pronounced by (Local hospital doctor) at 7:36 AM time of death . Review of Resident #140's EMS Care Report Summary dated [DATE] revealed, . Call received: 7:21 AM . Narrative History Text: Events leading to illness/injury: (EMS) called for 84 YOM (year old male) falls with unknown bleeding. Position Pt found/ Initial scene findings: EMS arrived on scene to find facility staff members outside the residence (sic) room with the door shut. Staff on scene said, (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235377	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Care Center	1050 Four Mile NW Grand Rapids, MI 49544

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	we found him this way and called you guys. EMS found the PT lying supine on the floor at the foot of his bed with a large amount of approximately 4-5 pints (of blood) around him on the floor. Staff on scene reports the PT has a fistula to his L (left) arm and reports the PT had dialysis yesterday. PT last seen at approximately 06:45 this morning to obtain vitals, she reports when she left the PT was seated on the edge of his bed awake and acting confused at baseline for his medical history of Alzheimer's (a form of dementia). EMS personnel noted the PT was still warm to the touch with no signs of rigger (sic) mortis (stiffening of the joints and muscles of a body a few hours after death) or lividity (purplish-red skin discoloration appearing on the lower parts of a body after death, caused by gravity pulling blood into the capillaries as circulation stops) present. PT had no pulse and was placed on the cardiac monitor, and an Asystole (a state where the heart shows no electrical activity and stops beating) was obtained in 3 leads. ADDITIONAL ASSESSMENT NOTES (IF APPLICABLE): Lividity and rigor mortis not present. PT has no carotid or radial pulses present. Asystole (the heart has completely stopped beating, with no electrical activity or contractions) present on the 4 lead. Obvious evidence of Exsanguination (the process of bleeding out or losing so much blood that it results in death) present on scene with blood loss approximately 4-5 pints on the floor between 2 locations. PT has a known fistula to his Left arm for dialysis. PT LAST SEEN AT AND BY: ([DATE] 06:45 by the CNA) PRONOUNCED AT: 07:36:00. PT'S BODY LEFT IN CUSTODY OF: (local police department), DNR PRESENT? Unknown. SIGNS AND SYMPTOMS OF OBVIOUS DEATH: exsanguination signs present. SIGNS OF OBVIOUS TRAUMA NOTED? (PT was found lying on the ground at the foot of his bed with approximately 4-5 pints of blood on the floor around him with another small puddle to the Left of his bed. Blood spatter on the bed frame, blankets, wall, door, and floor.) OTHER SCENE RELATED FINDINGS (IF APPLICABLE):PT had a bloody saturated 2x2 on the floor to the left of his bed with a small pool of blood by the chair. A bloody hand print was noted on the dresser at the foot of the bed directly across from where the pt was lying. Bloody trail from what looks like walker tires are on the floor from the chair to the left of the PT's bed to where he is lying with his walker present at the foot of the bed. Nurse on scene states the PT has Alzheimer's at baseline and last night was confused and was looking for breakfast during the night. The vitals cart was present in the PT's room with a set of vitals showing on the screen when EMS arrived. CNA reported she seen him last at 6:45 and he was sitting on the edge of his bed . In an interview on [DATE] at 9:41 AM, LPN Q reported CNA RR told her to come check on Resident #140 because she had just found him in his room in a large pool of blood. LPN Q reported that when she entered Resident #140's room, she found him lying on the floor in a large pool of blood. LPN Q reported that she checked Resident #140 for signs of life by looking for breath sounds and checking his pulse, and she noted that he did not have a pulse. LPN Q reported that she thought Resident #140 was bleeding from his fistula site, but she did not assess to determine where the bleeding was coming from so that she could attempt to stop the bleeding. LPN Q reported that she made the decision to not start CPR because she felt that there was too much blood and we would have just been sloshing around in the blood. LPN Q was unable to report who called 911, or if there was a delay in calling 911. In an interview on [DATE] at 10:21 AM, Registered Nurse (RN) TT reported he was notified by a CNA that LPN Q needed assistance with Resident #140. RN TT reported that he grabbed the facility's crash cart and went to Resident #140's room where he observed Resident #140 lying on his back on the floor at the foot of his bed in a pool of blood. RN TT reported he checked Resident #140 for a pulse, and noted that he did not have a pulse, but he did feel warm. RN TT reported that he did not assess for the source of Resident #140's bleeding, and he did not initiate CPR because he felt like it was a biohazard to do so because of the amount of blood Resident #140 had lost. RN TT was unable to report who called 911, or if there was a delay in the facility calling 911. In an interview on [DATE] at 10:58 AM, CNA RR reported that on [DATE] she had gotten shift report from CNA X who had told her that Resident #140 was awake, and that she had just checked on him around 6:45 AM. CNA RR reported that around 7:00 AM, she entered Resident #140's room and found Resident #140 on the floor (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235377	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Care Center	1050 Four Mile NW Grand Rapids, MI 49544

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	by his bed in a pool of blood. CNA RR reported that she tried to call out for help, but when staff did not come, she ran to find LPN Q. CNA RR reported that once LPN Q entered Resident #140's room, she stepped out of Resident #140's room. CNA RR reported that she did not call 911, and she was unable to report which staff member did. This writer attempted to contact CNA X on [DATE] at 9:15 AM. CNA X did not return this writer's call prior to survey exit. In an interview on [DATE] at 4:15 PM, CNA M reported that she was working on [DATE] when she heard LPN Q yelling out for help. CNA M reported that went to Resident #140's room where she saw a few other CNA's running from the room and saying that someone needed to call 911 and get help. CNA M reported that she ran to get more nurses and told RN TT that LPN Q needed help. CNA M reported that when she returned to Resident #140's room, she observed LPN Q checking Resident#140 for a pulse. CNA M reported that LPN Q looked overwhelmed and unsure of what to do. CNA M reported that she did not call 911 and she was not sure which staff member did. In an interview on [DATE] at 12:30 PM, RN Unit Manager (RN-UM) O reported that she was the on-call manager on the day that Resident #140 was found in his room. RN O reported that she was informed that staff had found Resident #140 when they were passing morning waters around 7:00 AM. RN O reported that there was no reason for staff to initiate CPR because Resident #140 had lost too much blood, and it was everywhere. RN O was not able to report if the staff that responded to Resident #140 had determined the cause of Resident #140's bleeding. RN-UM O reported that she did come to the facility to make sure the paperwork was good regarding Resident #140's death. RN-UM O reported that she did not think there was anything that the staff could have done differently when responding to Resident #140. RN-UM O was unable to report which staff member called 911, or if there was a delay in calling 911. In an interview on [DATE] at 12:12 PM, Director of Nursing (DON) B reported that she was aware of the incident with Resident #140 on [DATE]. DON B reported that she was informed that the nursing staff that found Resident #140 in a pool of blood did not initiate life saving measures because there were no signs of life in Resident #140, and there was too much blood loss to initiate CPR. DON B reported that the nursing staff thought that Resident #140's blood loss was from his fistula site. When this writer queried about how staff had determined how much blood Resident #140 had lost, DON B was unable to answer. When this writer queried as to how to the nursing staff knew that Resident #140's blood loss was from the fistula site, DON B was not able to confirm if nursing staff had assessed Resident #140's fistula site. DON B was unable to report which staff member had called 911, or if there was a delay in calling 911. DON B reported that she thought that the previous DON had completed an investigation into the incident, but she would need to find the paperwork regarding this. DON B was unable to provide any investigation reports prior to survey exit. In an interview on [DATE] at 12:21 PM, Nursing Home Administrator (NHA) A reported the facility did not complete an incident report, and the interdisciplinary team (IDT) did not meet to discuss the incident with Resident #140 because the facility had responded appropriately to the situation. NHA A reported Resident #140 was a full code, but there was no more blood to pump to his heart, so they could not do CPR. NHA A was not able to report how the nursing staff were able to determine that Resident #140 did not have enough blood for them to initiate CPR. Review of the facility's CPR policy last revised on [DATE] revealed, PURPOSE: To initiate Cardiopulmonary Resuscitation/CPR (using an AED device if available) for residents requesting full code or withholding cardiopulmonary resuscitation for residents who have declared a no-code status/DNR or who present with obvious signs of death per AHA. Procedure: .2. If a resident is noted to be without a pulse or respirations, the appropriate steps will be takenbased on Code status and other situations such as safety and any obvious signs of death. 3. The CPR certified professional will evaluate for responsiveness, if unresponsive they will activate the emergency response team. 4. The resident will be evaluated for pulse as well as respirations. 5. If the patient has a pulse but is not breathing rescue breaths will be provided. 6. If the patient does not have a pulse and they are assigned as a full code without obvious signs of death, chest compressions will be initiated with rescue breaths per AHA guidance . Review of Putting a stop to exsanguination ([DATE]) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235377	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Care Center	1050 Four Mile NW Grand Rapids, MI 49544

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	revealed, When blood is lost, the greatest immediate need is to stop further blood loss.Damage control resuscitation is now standard practice in many trauma settings. Damage control resuscitation is based on the principle that full, normal hemostasis does not necessarily need to be achieved at the first intervention. Part of this process is the recognition that there is not always time to get a patient to a secure, well-staffed and well stocked intensive care unit. The aim of damage control resuscitation is to maintain circulating volume, control hemorrhage, and correct the lethal triad until definitive intervention is appropriate. According to the 2024 American Heart Association and American Red Cross Guidelines for First Aid (2024 American Heart Association and American Red Cross Guidelines for First Aid | American Heart Association CPR & First Aid) , First aid for bleeding: When faced with life-threatening bleeding, the first aid provider should apply direct pressure followed by application of a tourniquet or wound packing if the location of the wound is amenable.Uncontrolled bleeding is the most important preventable cause of death in 35% of trauma patients and can occur before the arrival of emergency services. Life-threatening bleeding can be recognized by pooling of blood on the ground, blood that is rapidly flowing or spurting from the wound, bleeding that continues despite direct manual pressure, or bleeding that results in systemic symptoms such as drowsiness, dizziness, chest pain, or loss of consciousness. Because death can occur within minutes, first aid providers are essential in providing immediate care. Control of bleeding is a foundational first aid skill, and applying direct pressure is the mainstay of treatment. For extremity bleeding that is not effectively controlled with direct pressure, tourniquet application can be an appropriate intervention. Direct manual pressure is the hallmark of hemorrhage control. If available, hemostatic dressings (which contain materials that help promote blood clotting), pressure dressings, mechanical pressure devices, and tourniquets may augment the effectiveness of direct manual pressure or avoid the need for ongoing direct manual pressure.A person presenting with shock, including cardiogenic, hypovolemic, or hemorrhagic shock, may experience dizziness, difficulty breathing, chest pain, or skin mottling. While waiting for EMS, the first aid provider can position the person in a way to optimize circulation to vital organs such as the brain and to avoid decompensation. According to the 2025 American Heart Association Guidelines for CPR and ECC (CPR and ECC Guidelines | American Heart Association CPR & First Aid), Healthcare Professionals (HCPs) have a prima facie obligation to follow institutional policies regarding ethical issues in resuscitation in addition to the guidelines in this document. In turn, institutions have an obligation to develop ethically sound policies, educate HCPs on both policies and ethical guidelines, and provide the resources necessary to adhere to these standards and resolve difficult issues when they arise.Once initiated, resuscitation can be discontinued, but the decision not to initiate treatment is often irrevocable. Thus, HCPs should generally err on the side of providing resuscitation when uncertainty exists.focusing on the special circumstances as etiologies of cardiac arrest, provide and evaluate specific treatment options meant to be administered in addition to, and alongside, traditional resuscitation care. Unless otherwise specified, all patients should receive standard airway management, support of breathing, and treatment of hypotension, arrhythmias, and cardiac arrest consistent with local protocols and the resources available at the site of treatment. The Immediate Jeopardy that began on [DATE] was removed on [DATE] when the facility took the following actions to remove the immediacy: 1. Resident #140 involved no longer resides in the center as of [DATE].2. 67 of 67 residents with a full code advanced directive have been assessed and deemed in no immediate need of first aide or CPR as of 12-9-25. 66 out of 133 residents with DNR advanced directives have been assessed and deemed as not in immediate need of first aide.3. The CPR policy as reviewed on [DATE] by NHA and DON and deemed appropriate and in line with American Heart Association guidelines.4. Education began on [DATE] with licensed nurses on the CPR policy, including assessment, first aid and initiation of CPR in all events unless rigorous has set in and or the body is cold. The individual directing the code will assign tasks including the immediate notification of the 911 system. Education continued at the beginning of each shift until all staff members had received the education. As of [DATE] 31 of 42 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235377	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Care Center	1050 Four Mile NW Grand Rapids, MI 49544

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	licensed nurses have been educated. All licensed nurses will be educated prior to their next scheduled shift.5. Licensed nurse's CPR certifications were reviewed on [DATE] and up to date.6. A code blue drill was completed on [DATE] that included the participation of 18 staff members. A code blue drill will be held every 12-hour shift for 3 days and then weekly for 12 weeks.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235377	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Care Center	1050 Four Mile NW Grand Rapids, MI 49544

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect a resident's right to be free from resident-to-resident mental and verbal abuse for 2 (Resident #19 and Resident #96) of 3 residents reviewed for abuse, resulting in Resident #19 experiencing verbal threats and having profanity directed toward him by Resident #96. Findings include:Resident #19Review of an admission Record revealed Resident #19 was originally admitted to the facility on [DATE].Review of a Minimum Data Set (MDS) assessment for Resident #19 with a reference date of 10/15/25, revealed a Brief Interview for Mental Status (BIMS) assessment score of 15 /15, which indicated the resident was cognitively intact. Section E revealed Resident #19 did not exhibit physical or verbal behaviors directed toward others.Review of a Care Plan for Resident # with a reference date of 7/9/25 revealed the following focus/goal/interventions: Focus: I have an alteration in my MOOD state r/t (related to) decreased mobility.Goal: I will communicate my feelings as needed. Interventions: .Encourage me to interact with others. Resident #96Review of an admission Record revealed Resident #96 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: cerebral infarction due to embolism of left cerebral artery (left sided stroke primarily affects the right side of the body that may also cause speech issues, trouble understanding and cognitive problems like reasoning and mood changes).Review of a Minimum Data Set (MDS) assessment for Resident #96 with a reference date of 10/7/25, revealed Resident #96 could not complete a Brief Interview for Mental Status (BIMS) due to cognitive limitations. Section B revealed Resident #96's speech was clear, he could use distinct intelligible words and was sometimes understood. Section C of the MDS revealed Resident #96's short- and long-term memory appeared impaired, and he was moderately impaired for decision making.Review of a Care Plan for Resident #96 with a reference date of 1/8/25 revealed the following focus/goal/interventions: Focus: Resident has severe cognitive impairment. Goal: Display appropriate response to situation. Interventions: Anticipate needs, redirect me as needed, minimize.overstimulation, use brief/simple cues and repeat as needed.During an observation on 12/9/25 at 9:51am, Certified Nursing Assistant (CNA) SS and CNA CC assisted Resident #96 into his wheelchair in his room.During an observation on 12/9/25 at 9:53am, Resident #96 was heard from the hallway saying in a loud tone of voice, I'm going to kill that M***ER F***ER to CNA SS and CNA CC as the CNA's exited his room. Resident #96 exited the room directly behind CNA SS and CNA CC. CNA SS stated Head down to the gym to Resident #96 and CNA SS and CNA CC stepped off to the side of Resident #96's doorway and began talking to each other. Resident #96 quickly self-propelled his wheelchair into Resident #19's room, stopped his wheelchair near Resident #19's bed and yelled loudly in a deep, emotionally charged tone of voice: I'm going to kill you, you M***ER F***ER. You're dead, you M***ER F***ER, You're Dead!. CNA SS entered the room and removed Resident #96 from the unit.In an interview on 12/9/25 at 12:31pm, Resident #19 reported Resident #96 had threatened him a total of 3 times in recent months. Resident #19 began to cry and stated, I shouldn't feel threatened in my own home. Resident #19 reported he kept his curtain pulled around his bed and watched the reflection on his roommates television to see if Resident #96 was entering his room. When queried why he watched for Resident #96, Resident #19 stated because I want to be ready for him so I can protect myself. Resident #19 reported the first time Resident #96 verbally assaulted him, he was fearful that Resident #96 was going to hit him, so he pushed his bedside table between himself and Resident #96. When further queried, Resident #19 reported he worried Resident #96 would try to physically assault him. Resident #19 reported staff were aware of the previous incidents in which Resident #96 threatened him and as a result, Resident #96 was supposed to be supervised when he was in the hallway. As he cried, Resident #19 reported he liked living there but following this incident, he was considering moving to another facility to protect his well-being.In an interview on (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235377	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Care Center	1050 Four Mile NW Grand Rapids, MI 49544

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	12/9/25 at 1:52pm, CNA CC reported there had been similar incidents in which Resident #96 threatened Resident #19. CNA CC reported during one incident, she heard Resident #96 yelling at Resident #19, saying he wanted to fight Resident #19. CNA CC confirmed she was not unsure if previous altercations between Resident #96 and Resident #19 had been reported.In an interview on 12/9/25 at 1:27pm, CNA SS reported she witnessed Resident #96 yelling at and directing profanity toward Resident #19 today but had also witnessed Resident #96 doing the same thing prior to today. CNA SS reported Resident #96 had been upset with Resident #19 for several weeks because he was bothered by someone's television and thought it was Resident #19's. CNA SS reported staff told Resident #96 repeatedly that Resident #19 did not play his television loudly, but Resident #96 continued to fixate on him. When queried about interventions that had been put in place to avoid Resident #19 being verbally abused by Resident #96, CNA SS reported she was not aware of any interventions the facility had implemented. CNA SS reported Resident #19 was crying after the altercation with Resident #96 on this date.In an interview on 12/10/25 at 10:48am, Unit Manager (UM) XX reported CNA SS informed him of an incident on 12/9/25 at approximately 9:55am during which Resident #96 had yelled and directly profanity at Resident #19. UM XX reported CNA SS told him during the incident, Resident #19 was yelling for help, and she removed Resident #96 from the room. UM XX reported he met with Resident #19 after the incident and described Resident #19 as emotionally upset by the incident. UM XX reported Resident #96 was always angry initially when he entered the hallway from his room, but he was not aware of any interventions that had been put in place to avoid Resident #96 directing his anger toward other residents, including Resident #19. UM XX confirmed any incident involving someone yelling and/or directing profanity at a resident should be immediately reported Nursing Home Administrator (NHA) A. UM X confirmed he reported the incident to NHA A after he spoke to CNA SS. UM X reported he was not aware of any other altercations between Resident #96 and Resident #19.Review of a Nurse's Note for Resident #19, written by UM X on 12/9/25 at 2:16pm revealed Follow up with resident regarding another resident across the hall entering his room and yelling.Resident stated.he felt safe at the moment. Informed resident we will follow up with the other resident.Resident was pleased in regards to what we discussed.In an interview on 12/10/25 at 2:34pm, Social Services Director (SSD) L reported Resident #96 had previously expressed frustration and anger about hearing something that he believed to be Resident #19's television. SSD L reported Resident #96 became fixated on his beliefs and could not be redirected. SSD L reported she was not aware of any incidents in which Resident #96 threatened Resident #19 and had not been informed about the incident on this date.In an interview on 12/10/25 at 11:18am, Physical Therapist (PT) HH reported Resident #96 had expressed ongoing anger about hearing someone's television and despite being redirected, continued to believe that Resident #19 was to blame. When further queried, PT HH reported Resident #96 had expressed anger and agitation about Resident #19 for more than a month. PT HH reported Resident #96 expressed he felt Resident #19 was acting deliberately disrespectful toward him, despite being told repeatedly that Resident #19 was not playing his television loudly. PT HH reported hall staff denied hearing anyone playing their television loudly.In an interview on 12/10/25, NHA A reported she was not aware of any previous altercations between Resident #96 and Resident #19. NHA A reported she spoke with Resident #19 several hours after the incident on 12/10/25 and confirmed the Resident #19 was emotionally upset by the incident. NHA A confirmed Resident #19 reported he would feel safer if Resident #96 was not in a room across the hall from him.Review of an Abuse Policy with a reference date of 3/15/23 revealed POLICY STATEMENT 1. (facility name omitted) will not tolerate verbal, sexual, physical or mental abuse.PROCEDURE: a. DEFINITIONS.iii) Mental Abuse includes, .harassment, and threats.ix) Verbal abuse refers to any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents. Verbal abuse includes.offensive or disapproving terms to any resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235377	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Care Center	1050 Four Mile NW Grand Rapids, MI 49544

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on observation, interview, and record review the facility failed to ensure adaptive dining equipment was provided consistently for 3 (Resident #62, 132, and 102) of 27 residents reviewed for dining resulting in decreased independence with dining, difficulty eating/drinking, and the potential for dehydration and/or weight loss.Findings include:Resident #62:Review of Resident #62's nutrition care plan, revised 9/30/25, stated, Focus.Nutrition risk r/t (related to) anoxic (deprived of adequate oxygen) brain damage, L (left) sided spastic hemiplegia (muscle stiffness and weakness on one side of the body).Interventions.two handled cups with sip lids.Review of Resident #62's brief interview for mental status score, dated 10/13/25, was 5 which reflected severe cognitive impairment. During an observation on 12/08/2025 at 12:19 PM, Resident #62 was eating lunch in the dining room with Certified Nurse Aid CC seated next to him. Resident #62 was independently taking fluids but required staff assistance to eat the food on his plate. Resident #62 had two double handle cups with sip lids but the cup containing red liquid, which was one fourth full, had a lid that was concave and a tiny hole the size of a standard straw (intended to hold a straw). Resident #62 was observed bringing the cup to his mouth but unable to get juice from the cup as the lid wasn't allowing fluids to leave the cup and enter his mouth when he tilted the cup. The lid on this cup was not a sip lid.During an observation on 12/08/2025 at 2:11 PM, Resident #62 was seated upright in his wheelchair in his room and was observed to be able to drink fluids independently with a double handle cup with sip lid. On his bedside table was a clear single handle cup with spout lid (a type of sip lid). Resident #62 was nonverbal and unable to answer questions.During an observation on 12/09/2025 9:02 at AM, Resident #62 was seated upright in his wheelchair in his room next to his bed. The bedside table was over the bed directly next to him in the wheelchair. The double handle cup with spout lid was placed out of his reach. The only drink within his reach was a disposable foam cup (no handles) with disposable lid (not a sip lid). This foam cup contained water.During an interview on 12/09/2025 at 1:09 PM, Registered Dietitian (RD) L confirmed the concave lid with hole, which Resident #62 was observed to have been provided on 12/08/2025 at 12:19 PM, was not a sip lid and he should have received a sip lid with his fluids. RD L confirmed dietary staff would provide the adaptive dining equipment served at meals for the residents. RD L reported Resident #62 should have received the adaptive dining equipment noted in his care plan, on his meal ticket, and in his diet order. RD L confirmed occupational therapy would have made the recommendation for the two handle cup with sip lid for Resident #62. During an interview on 12/09/2025 at 4:20 PM, RD L reported various unidentified certified nurse aides reported they used the disposable foam cup with water in Resident #62's room to fill the adaptive equipment, two handle cup with sip lid, when Resident #62 was in his room and wasn't expected to drink from the foam cup.Review of Resident #62's diet order, revised 8/28/25, stated, Directions.two handle cup with sip lid. Resident #132:Review of Resident #132's nutrition/hydration care plan, revised 11/21/25, stated, Focus.I am at risk for alteration in nutrition/hydration status r/t (related to) dementia (impaired cognition), hemiplegia/hemiparesis (inability to move one side of the body).and dysphagia (difficulty swallowing).Interventions.Two handled cup with sip top lid, spoon curved left.Review of Resident #132's brief interview for mental status score, dated 11/13/25, was scored 4 which reflected severe cognitive impairment. During an observation on 12/09/2025 at 12:26 PM, Resident #132 was observed dining independently in his room. Resident #132 was served two beverages, one brown and one white, in double handle cups with spout lid. A third beverage served was water which was served in disposable foam cup, disposable lid, and straw. Resident #132 was provided with straight/regular metal dining utensils. The fork, knife, and spoon were all straight and were not bent left. Resident #132 was observed eating his pureed food with his finger. Resident #132 was confused and was unable to answer questions. The meal ticket on his tray stated, ADAPT EQUIP (adaptive equipment): . 2 Handled Cup with Sip Lid, Bent Left Utensils.During an observation on 12/09/2025 at (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235377	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Care Center	1050 Four Mile NW Grand Rapids, MI 49544

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4:47 PM, Resident #132 was in bed in his room with the head of bed elevated. On his bedside table placed over him was what appeared to be water in a disposable foam cup with disposable lid and straw. There were no two handle cups with sip lid on the tray table or observed in the room.During an observation on 12/10/2025 at 7:58 AM, Resident #132 was in bed in his room with the head of bed elevated. On his bedside table was what appeared to be water in a disposable foam cup with disposable lid and straw. There was not a two handle cup with sip lid on the tray table or observed in the room.During an observation on 12/10/2025 at 11:01 AM, Resident #132 was seated in his wheelchair at the table in the day room at the end of the 500 hall. Resident #132's beverage on the table directly next to him was served in a disposable foam cup, disposable lid, and straw. After immediately walking down to Resident #132's room it was observed that two adaptive two handle cups with sip lids were in his room. Review of Resident #132's physician order, revised 6/20/25, stated, .spoon curved left; 2 handle cup w/ (with) sip top lid.Review of Resident #132's Dietary Profile assessment, dated 11/21/25, stated, Utensils.Dining aides.bent L (left) utensils.Resident #102:Review of Resident #102's nutrition care plan, revised 11/18/25, stated, Focus.Nutrition risk r/t (related to) dementia.Interventions.Diet order: .Scoop plate.Review of Resident #102's brief interview for mental status score, dated 11/28/25, was scored 3 which reflected severe cognitive impairment.During an observation on 12/10/2025 at 12:21 PM, Resident #102 was observed eating lunch independently in the dining room. Resident #102 was served lunch on a regular plate and not a scoop plate (a type of dish specifically designed with a raised edge to make it easier to scoop food onto a utensil). There was food covering the outside lip of half the plate, with food pushed off the plate and onto the tablecloth surrounding the plate.Review of Resident #102's physician order, revised 11/7/25, stated, Regular diet.Directions.Scoop Plate. Review of Resident #102's Dietary Profile assessment, dated 11/13/25, stated, .Utensils.Dining aides.scoop plate.Eating Assistance.Independent.Review of the facility's activities of daily living (ADL) (daily life functions) policy, dated 7/1/2008, stated, Use adaptive equipment as directed PRN (as needed).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235377	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Care Center	1050 Four Mile NW Grand Rapids, MI 49544

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report injuries of unknown origin to the State Agency in a timely manner for 2 (Resident #19 and Resident #96) of 3 residents reviewed for abuse and reporting, resulting in the potential for ongoing mistreatment to go unrecognized.Findings include:Resident #19Review of an admission Record revealed Resident #19 was originally admitted to the facility on [DATE].Review of a Minimum Data Set (MDS) assessment for Resident #19 with a reference date of 10/15/25, revealed a Brief Interview for Mental Status (BIMS) assessment score of 15 /15, which indicated the resident was cognitively intact. Section E revealed Resident #19 did not exhibit physical or verbal behaviors directed toward others.Resident #96Review of an admission Record revealed Resident #96 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: cerebral infarction due to embolism of left cerebral artery (left sided stroke primarily affects the right side of the body that may also cause speech issues, trouble understanding and cognitive problems like reasoning and mood changes).Review of a Minimum Data Set (MDS) assessment for Resident #96 with a reference date of 10/7/25, revealed Resident #96 could not complete a Brief Interview for Mental Status (BIMS) due to cognitive limitations. Section B revealed Resident #96's speech was clear; he could use distinct intelligible words and was sometimes understood. Section C of the MDS revealed Resident #96's short- and long-term memory appeared impaired, and he was moderately impaired for decision making.Review of a Care Plan for Resident #96 with a reference date of 1/8/25 revealed the following focus/goal/interventions: Focus: Resident has severe cognitive impairment. Goal: Display appropriate response to situation. Interventions: Anticipate needs, redirect me as needed, minimize.overstimulation, use brief/simple cues and repeat as needed.During an observation on 12/9/25 at 9:53am, Resident #96 was heard from the hallway saying in a loud tone of voice, I'm going to kill that M***ER F***ER to Certified Nursing Assistant (CNA) SS and CNA CC as the CNA's exited his room. Resident #96 exited the room directly behind CNA SS and CNA CC. CNA SS stated Head down to the gym to Resident #96. CNA SS and CNA CC stepped off to the side of Resident #96's doorway and began talking to each other. Resident #96 quickly self-propelled his wheelchair into Resident #19's room, stopped his wheelchair near Resident #19's bed and yelled loudly in a deep, emotionally charged tone of voice: I'm going to kill you, you M***ER F***ER. You're dead, you M***ER F***ER, You're Dead!. CNA SS entered the room and removed Resident #96 from the unit.In an interview on 12/09/2025 at 2:43 PM CNA SS reported she told the nurse and Unit Manager (UM) XX about Resident #96 yelling profanities at Resident #19 immediately after the incident occurred.In an interview on 12/10/25 at 10:48am, Unit Manager (UM) XX reported CNA SS informed him of an incident on 12/9/25 at approximately 9:55am during which Resident #96 had yelled and directed profanity at Resident #19. UM XX reported CNA SS told him during the incident, Resident #19 was yelling for help, and she removed Resident #96 from the room. UM X confirmed he reported the incident to NHA A directly after he spoke to CNA SS. In an interview on 12/10/25, NHA A reported she was informed of the incident between Resident #96 and Resident #19 during the morning of 12/9/25. NHA A reported she was delayed in interviewing Resident #19 but upon doing so, saw the resident was emotionally upset by the situation. NHA A confirmed the resident reported he would feel safer if the facility ensured Resident #96 was not near him. Following the resident interview, NHA A reported the incident to the State Agency as possible abuse. NHA A confirmed the incident was not reported to the State Agency within 2 hours as required.Review of an Abuse policy with a reference date of 3/15/23 revealed .f) REPORTING/RESPONSE i) For the alleged violation involving abuse.the Center will report immediately but not later than two hours after the allegation is made, if the event involves abuse.to officials (including the state survey agency) .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235377	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Care Center	1050 Four Mile NW Grand Rapids, MI 49544

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide timely and consistent ADL (activities of daily living) care to 1 resident (Resident #117) of 13 residents reviewed for ADL care, resulting in inadequate incontinence care and repositioning for meals and the potential for avoidable negative physical and psychosocial outcomes for resident's who are dependent on staff for assistance. Findings include:Review of an admission Record revealed Resident #117 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: urinary incontinence and overactive bladder. Review of a Minimum Data Set (MDS) assessment for Resident #117, with a reference date of 11/30/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #117 was cognitively intact. Review of Resident #117's ADL Care Plan revealed, .actual ADL deficit. Date initiated: 9/3/25. Interventions: Boost resident at the beginning of each CNA shift to a 45 degree angle. Review of Resident #117's Skin Care Plan revealed, .urine retention, urge incontinence.MASD (moisture associated skin disorder) left inner thigh.Date initiated: 9/3/24.Interventions: Apply protective skin barrier after each incontinence episode.Encourage and assist me to make small, frequent shifts in my position per standards of care and as I allow.Please help me get turned and repositioned while in bed or in my wheelchair per standards of care and as I allow.During an observation and interview on 12/08/2025 at 12:10 PM Resident #117 was lying in her bed eating lunch. Resident #117's head of bed (HOB) was elevated to approximately 45 degrees, but her upper body was nearly flat on the bed due to being slouched down in bed so far. Resident #117 reported that she was very uncomfortable, but she had given up on asking to be boosted up in bed because staff just told her she was already high enough. Resident #117 reported that she had not received incontinence care yet that day and usually only gets assistance once a shift.During an observation and interview on 12/10/2025 at 12:10 PM Resident #117 was lying in her bed. Resident #117 reported that the only time she gets rolled over and off her bottom was once every 8 hours. Resident #117 reported that she was wet with urine and the last time someone checked or changed her was at 5:30 AM (>6 hours ago) that day and that her bottom is getting sore. Resident #117 reported that she had skin issues on her buttock from being wet all the time. Resident #117 reported that she usually gets out of bed and into her chair after lunch and then sits there with an uncomfortable fish net hoyer sling underneath her until after supper. Resident #117 reported that she was able to ask for assistance but was not always able to feel when she was wet, therefore preferred to be woken up during the day for incontinence care and repositioning every 2 hours.In an interview on 12/10/2025 at 12:25 PM, CNA F reported that Resident #117 required 2 people for cares and she had not been in the room yet that day to assist with any cares.In an interview on 12/10/2025 at 12:26 PM, CNA C reported that she had not been in to provide care to Resident #17 yet that day and reported that the resident preferred to sleep most of first shift and did not like to be woken up for incontinence care. CNA C reported that Resident #117 was able to let staff know when she needs care. During an observation on 12/10/2025 at 12:45 PM, CNA C was in Resident #117's room preparing to provide incontinence care and get her up into her chair. CNA C donned gloves, removed the blanket and Resident #117 incontinence brief was visibly saturated with urine. CNA C detached the brief and began cleaning the front peri-area. The resident was then rolled onto her right side and the heavily saturated brief was removed. Resident #117's buttocks were observed red with creases from the brief and bedding, and there was a small superficial open area on the residents right inner thigh, that CNA C reported was previously a bigger wound. CNA C continued to clean the peri-area and buttocks, where a small amount of BM (bowel movement) was noted on the washcloths.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235377	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Care Center	1050 Four Mile NW Grand Rapids, MI 49544

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2660756. Based on interview and record review, the facility failed to ensure that residents received necessary treatments and care for diabetes in accordance with professional standards of practice for 1(Resident #142) of 27 residents reviewed for quality of care resulting in Resident #142 missing blood glucose monitoring and insulin (a hormone produced in the pancreas, which regulates the amount of glucose in the blood) which placed Resident #142 at risk for serious health complications. Findings include: Resident #142Review of an admission Record revealed Resident #142 was originally admitted to the facility on [DATE] with pertinent diagnoses which included type 2 diabetes (a chronic disease where the body either doesn't make enough insulin or doesn't use it properly, leading to high blood sugar levels) and essential hypertension (high blood pressure). Review of Resident #142's Orders revealed, Blood glucose monitoring two times a day related to type 2 diabetes mellitus without complications for 7 days. Start date: 8/7/25. End date: 8/14/25. Insulin Lispro Injection Solution (Insulin Lispro) Inject as per sliding scale: .subcutaneously three times a day for dm (diabetes mellitus.) Start date: 12/23/24. Order status: discontinued. Review of Resident #142's Treatment Administration Record for August 2025, September 2025, and October 2025 revealed that Resident #142 did not have blood glucose monitoring documented after 8/14/25. It was also noted that Resident #142 did not have insulin orders documented as administered after 8/14/25. Review of Resident #142's Blood Sugar Summary indicated that Resident #142 did not have blood glucose results documented after 8/14/25. It was noted that Resident #142 had several elevated blood glucose levels documented which included 478.0 on 8/13/25, 307 on 8/12/25, 353 on 8/13/25, 298 on 8/13/25, and 254 on 8/8/25. Review of Resident #142's Physician's note dated 8/8/25 and documented by Nurse Practitioner (NP) MM revealed, DMT2 (diabetes mellitus type 2) : Last A1C 6.5% (test measures the average amount of sugar in your blood over the past few months). Continue Lantus (insulin) and ISS (insulin sliding scale). Monitor blood sugar trends. Elevated likely due to Prednisone (steroid) course, prednisone is tapering off so will hold off on adjustment of Lantus at this time. Continue ISS Review of Resident #142's Physician's note dated 9/4/25 and documented by Nurse Practitioner (NP) LL revealed, DMT2 (diabetes mellitus type 2): Controlled. Continue insulin and monitor blood sugar trends .Review of Resident #142's Physician note dated 10/8/25 and documented by Medical Doctor (MD) KK revealed, Type 2 diabetes mellitus: Euglycemic (normal levels of glucose in the blood), medically controlled. Continue with insulin and continue monitors with accu-checks. (blood glucose monitor) In an interview on 12/8/25 at 8:12 AM, Family Member (FM) JJ reported Resident #142 had discharged from the facility on 10/26/25. FM JJ reported that when Resident #142 discharged , the facility did not indicate that she needed blood glucose monitoring and insulin for her diabetes. FM JJ reported that within two days of discharging from the facility, Resident #142 fell ill, and went to hospital where it was discovered that her blood glucose level was in the 600's, and she required hospitalization. In an interview on 12/10/2025 at 12:27 PM, Licensed Practical Nurse Unit-Manager (LPN-UM) UU reported that Resident #142 had been readmitted to the facility after a short hospital stay in August 2025. LPN-UM UU reviewed Resident #142's hospital After Visit Summary with this writer and noted that the provider that re-admitted Resident #142 ordered blood glucose monitoring for 7 days. LPN-UM UU reported that the provider that assessed Resident #142 after 8/14/25 when the order for blood glucose monitoring was completed was responsible for re-ordering blood glucose monitoring and insulin for Resident #142. LPN-UM UU reviewed Resident #142's electronic health record (EHR) and confirmed that Resident #142 did not have blood glucose monitoring or insulin orders placed after 8/14/25. In an interview on 12/10/2025 at 12:17 PM, MD KK reported that he was not sure why Resident #142's insulin had been discontinued. MD KK reviewed Resident #142's blood glucose levels from August 2025 and confirmed that the blood glucose levels were not considered euglycemic. MD KK confirmed that he did assess Resident #142 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235377	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Care Center	1050 Four Mile NW Grand Rapids, MI 49544

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 10/8/25, and that he did notice at that time that the facility had not been checking Resident #142's blood glucose levels, but he did not look into it further, and that was an error on my part.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235377	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Care Center	1050 Four Mile NW Grand Rapids, MI 49544

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to 2660756 Based on interview and record review, the facility failed to ensure the physician notes reflected accurate representation of the resident's current condition and meaningful assessments of the residents' condition were completed for 1 (Resident # 142) of 27 residents reviewed for quality of care resulting in the lack of coordination of care and insufficient treatment for diabetes mellitus (a chronic disease where the body either doesn't make enough insulin or doesn't use it properly, leading to high blood sugar levels). Findings include: Resident #142Review of an admission Record revealed Resident #142 was originally admitted to the facility on [DATE] with pertinent diagnoses which included type 2 diabetes (a chronic disease where the body either doesn't make enough insulin or doesn't use it properly, leading to high blood sugar levels) and essential hypertension (high blood pressure). Review of Resident #142's Orders revealed, Blood glucose monitoring two times a day related to type 2 diabetes mellitus without complications for 7 days. Start date: 8/7/25. End date: 8/14/25. Insulin Lispro Injection Solution (Insulin Lispro) Inject as per sliding scale: .subcutaneously three times a day for dm (diabetes mellitus.) Start date: 12/23/24. Order status: discontinued. Review of Resident #142's Treatment Administration Record for August 2025, September 2025, and October 2025 revealed that Resident #142 did not have blood glucose monitoring documented after 8/14/25. It was also noted that Resident #142 did not have insulin orders documented as administered after 8/14/25. Review of Resident #142's Blood Sugar Summary indicated that Resident #142 did not have blood glucose results documented after 8/14/25. It was noted that Resident #142 had several elevated blood glucose levels documented which included 478.0 on 8/13/25, 307 on 8/12/25, 353 on 8/13/25, 298 on 8/13/25, and 254 on 8/8/25. Review of Resident #142's Physician's note dated 8/8/25 and documented by Nurse Practitioner (NP) MM revealed, DMT2 (diabetes mellitus type 2) : Last A1C 6.5% (test measures the average amount of sugar in your blood over the past few months). Continue Lantus (insulin) and ISS (insulin sliding scale). Monitor blood sugar trends. Elevated likely due to Prednisone (steroid) course, prednisone is tapering off so will hold off on adjustment of Lantus at this time. Continue ISS Review of Resident #142's Physician's note dated 9/4/25 and documented by Nurse Practitioner (NP) LL revealed, DMT2 (diabetes mellitus type 2): Controlled. Continue insulin and monitor blood sugar trends .Review of Resident #142's Physician note dated 10/8/25 and documented by Medical Doctor (MD) KK revealed, Type 2 diabetes mellitus: Euglycemic (normal levels of glucose in the blood), medically controlled. Continue with insulin and continue monitors with accu-checks. (blood glucose monitor) In an interview on 12/10/2025 at 12:27 PM, Licensed Practical Nurse Unit-Manager (LPN-UM) UU reported that Resident #142 had been readmitted to the facility after a short hospital stay in August 2025. LPN-UM UU reviewed Resident #142's hospital After Visit Summary with this writer and noted that the provider that re-admitted Resident #142 ordered blood glucose monitoring for 7 days. LPN-UM UU reported that the provider that assessed Resident #142 after 8/14/25 when the order for blood glucose monitoring was completed was responsible for re-ordering blood glucose monitoring and insulin for Resident #142. LPN-UM UU reviewed Resident #142's electronic health record (EHR) and confirmed that Resident #142 did not have blood glucose monitoring or insulin orders placed after 8/14/25. In an interview on 12/10/2025 at 12:17 PM, MD KK reported that he was not sure why Resident #142's insulin had been discontinued. MD KK reviewed Resident #142's blood glucose levels from August 2025 and confirmed that the blood glucose levels were not considered euglycemic. MD KK confirmed that he did assess Resident #142 on 10/8/25, and that he did notice at that time that the facility had not been checking Resident #142's blood glucose levels, but he did not look into it further, and that was an error on my part. MD KK confirmed that NP MM: and NP LL had also assessed Resident #142 after 8/14/25 and did not review her orders for blood glucose monitoring or insulin but had (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235377	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Care Center	1050 Four Mile NW Grand Rapids, MI 49544

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented that Resident #142 was supposed to continue with blood glucose monitoring and insulin which she did not have active orders for.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235377	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Care Center	1050 Four Mile NW Grand Rapids, MI 49544

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure Contact Precautions (Transmission based measure implemented to a resident known or suspected to be infected with a microorganism that can be transmitted by direct contact with other residents or indirect contact with environmental surfaces) were effectively in place for 1 resident (#1), and ensure that standard infection control practices were properly implemented for 2 residents (Resident #3 and #117) from a total of 5 residents reviewed for infection control practice, resulting in the potential for transmission of MDRO (multidrug-resistant organisms) and cross contamination of bacteria to a suspectable population.Findings include:Resident #1Review of an admission Record revealed Resident #1 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: sepsis (a life-threatening medical emergency caused by your bodies response to overwhelming infection) and MRSA (a type of infection that can be resistant to antibiotics therefore difficult to treat).Review of Resident #1's Physician Orders revealed, Transmission based precautions: contact precautions three times a day for MRSA infection. Start date: 12/5/25During an observation on 12/8/25 at 10:47 AM Resident #1's room was observed with contact precautions posted and gowns hanging on the door. The sign indicated to don gloves and a gown prior to entering the room. There were no gloves outside of the resident's room.During an observation and interview on 12/09/2025 at 9:07 AM Resident #1's room was observed again with contact precautions posted, gowns hanging on the door but no gloves outside of the room. Resident #1 reported that he had a bad infection in his foot and is getting an IV (intra venous) antibiotic for it. The resident asked this surveyor for assistance with his bed controls. This surveyor asked an unknown therapy staff member to assist the resident. Observed that staff member don a gown and then walk into the room and look for gloves.During an observation on 12/10/25 at 8:53 AM Resident #1's room was observed with a cart outside of the door that contained gowns and gloves.In an interview on 12/10/2025 at 9:04 AM, Infection Preventionist (IP) H reported that earlier that day a Certified Nursing Assistant (CNA) had made her aware that Resident #1 did not have gloves available outside of his room, therefore she made sure a cart with gowns and gloves was put in place right away. IP H reported that the resident had recently returned from the hospital with MRSA infection and was on contact precautions. IP H reported that with contact precautions staff would be required to don gloves and a gown prior to entering the resident's room and before making contact with anything inside of the room.Resident #3Review of an admission Record revealed Resident #3 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: stage 4 pressure ulcer sacral region. Review of Resident #3's Physician Orders revealed, Enhanced barrier precautions as directed. This includes gown and gloves for high-contact resident care activities. Catheter, wounds. Start Date: 9/4/25.During an observation and interview on 12/08/2025 at 2:25 PM Resident #3 was lying in bed and CNA F and CNA Y were preparing to provide incontinence care. It was noted that Resident #3 had orders for enhanced barrier precautions due to a foley catheter and chronic wounds. Registered Nurse (RN) V was present in the room to complete pressure wound dressing change on the resident's bottom. Resident #3 had bandages covering wounds on both heels, bottom of left foot, right lower leg and upper buttocks. RN V reported that she was only changing the dressing on the resident's buttocks at this time. During cares CNA F was providing the direct care and CNA Y was assisting with positioning. CNA F was observed changing her gloves after incontinence care was completed but did not perform hand hygiene prior to donning clean gloves and resuming care. RN V donned 2 pair of gloves prior to starting the wound care, then discarded the top pair of gloves after removing the soiled dressing and then continuing wound care with the second pair of gloves that were already in place. RN V was not observed performing hand hygiene at any time during care. RN V verbalized to CNA F that she used the double glove technique so that she didn't have to stop and change gloves during care. In an interview on 12/10/2025 at 9:54 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235377	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Care Center	1050 Four Mile NW Grand Rapids, MI 49544

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	AM, CNA F reported that she did not perform hand hygiene between glove changes during Resident #3's care. CNA F reported that she knew of coworkers that double glove during care but did not know that it was a concern. In an interview on 12/10/2025 at 11:22 AM, RN V reported that she used the double glove method for safety and so that she can easily remove soiled gloves during care. RN V reported that she did not perform hand hygiene when removing soiled gloves if she had another pair of gloves on underneath them and was not aware that it would be an infection control concern. Resident #117Review of an admission Record revealed Resident #117 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: urinary incontinence and overactive bladder. During an observation and interview on 12/10/2025 at 12:10 PM Resident #117 was lying in her bed. Resident #117 reported that the only time she gets rolled over and off her bottom was once every 8 hours. Resident #117 reported that she was wet with urine and the last time someone checked or changed her was at 5:30 AM (>6 hours ago) that day and that her bottom is getting sore. During an observation on 12/10/2025 at 12:45 PM, CNA C was in Resident #117's room preparing to provide incontinence care and get her up into her chair. CNA C donned gloves, removed the blanket and Resident #117 incontinence brief was visibly saturated with urine. CNA C detached the brief and began cleaning the front peri-area. The resident was then rolled onto her right side and the heavily saturated brief was removed. Resident #117's buttocks were observed red with creases from the brief and the bedding and there was a small superficial open area on the residents right inner thigh, that CNA C reported was previously a bigger wound. CNA C continued to clean the peri-area and buttocks, where a small amount of BM (bowel movement) was noted on the washcloths. CNA C did not change her soiled gloves. CNA C obtained cream from the resident's nightstand, by putting her gloved hand into the container, to scoop it out and applied it to the resident's buttocks. Then placed a new brief and the hoyer sling under the resident and rolled the resident onto her back. Then with the same gloves on CNA C obtained a different cream from the nightstand drawer and applied it to the resident's front peri-area. When care was finished, CNA C removed her soiled gloves, did not perform hand hygiene, then donned clean gloves to gather the soiled linens. In an interview on 12/10/2025 at 9:04 AM, IP H reported that she monitored infection control practices by the facility staff during daily rounds and occasionally observed wound care. IP H reported that staff are trained to change gloves any time they become soiled, whether it is visible or not and to perform hand hygiene after every time gloves are removed. IP H reported that if gloves become visibly soiled, staff are expected to wash their hands with soap and water, but hand sanitizer can be utilized at other times. IP H reported that double gloving is not an acceptable practice.